RULE-MAKING ORDER

(RCW 34.05.360)

CR-103 (12/31/00)

Agency: Insurance Commissioner's Office

X Permanent Rule
☐ Emergency Rule
☐ Expedited Repeal

(1) Date of adoption: January 9, 2001

(2) Purpose: The proposed rules will implement the recently enacted "Patient Bill of Rights" chapter 5, laws of 2000 (E2SSB 6199).

Insurance Commissioner Matter No. R 2000-02

(3) Citation of existing rules affected by this order:

Repealed: 284-43-610
Amended: 284-43-130, 284-43-200, 284-43-60
Suspended:

(4) Statutory authority for adoption:

Other Authority: RCWs 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200. 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535

PERMANENT RULE ONLY (Including EXPEDITED ADOPTION)

Adopted under notice filed as WSR **00-22-119** on 11/1/00 (date).

Describe any changes other than editing from proposed to adopted version: *' 284-43-130* - DEFINITIONS Three new definitions are added to the chapter for clarification: "Adverse determination", Certification", and "clinical review criteria." Grievance is amended to include "oral" complaints. The changes to the definition of "health plan" that previously included state programs has been removed. *' 284-43-200* - NETWORK ADEQUACY (1) - (3) Choice among alternative care providers is explicitly recognized in the network adequacy standards. Choice of specialists is removed along with other language governing adequacy determinations. **Continued on reverse side….**

EMERGENCY RULE ONLY

Under RCW 34.05.350 the agency for good cause finds:

☐ (a) That immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

☐ (b) That state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.

Reasons for this finding:

EXPEDITED REPEAL ONLY

Under Preproposal Statement of Inquiry filed as WSR _____ on _____ (date)

(5.3) Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?:

☐ Yes ☐ No If Yes, explain:

(6) Effective date of rule:

Permanent Rules or Expedited Repeal	Emergency Rules
X 31 days after filing	☐ Immediately
☐ Other (specify) _____*	☐ Later (specify) _____

***(If less than 31 days after filing, specific finding in 5.3 under RCW 34.05.380(3) is required)**

CODE REVISER USE ONLY

CODE REVISER'S OFFICE
STATE OF WASHINGTON
FILED

JAN 9 2001

TIME 11:19 AM
WSR 01-03-033

Name (Type or Print)
DEBORAH SENN

Signature

Title
INSURANCE COMMISSIONER

Date
January 9, 2001

Describe any changes other than editing from proposed to adopted version - continued from front:

Carriers may demonstrate adequacy with reference to accepted government and national accreditation programs. (4) Drive time standards for network adequacy are removed and replaced with a general standard to reduce the distance that consumers must travel for care. (7) Carriers must allow American Indians to use tribal health care facilities. Carriers can pay at the network rate and only for medically necessary services that are covered benefits. ' *284-43-251* - ACCESS TO PROVIDERS Most provisions of this new section parallel the statutory provisions of the PBOR. ' *284-43-410* - UTILIZATION REVIEW This section sets general standards for utilization review and closely follows the PBOR. The section has been rewritten since first proposed to permit carriers to meet the standard through national accreditation programs. Other new standards include: limits on the collection of health information, prohibitions on retaliation against providers who dispute payments, requirements that carriers only use utilization standards that have been communicated to providers, and prohibitions on charging for second opinions mandated by PBOR. ' *284-43-820* - PRESCRIPTION DRUG DISCLOSURE This section sets forth extensive rules for the disclosure of drug formularies. ' *284-43-899* - EFFECTIVE DATE July 1, 2001.

Note: If any category is left blank, it will be calculated as zero. No descriptive text.

Count by whole WAC sections only, from the WAC number through the history note.
A section may be counted in more than one category.

The number of sections adopted in order to comply with:

Federal statute:	New	_____	Amended	_____	Repealed	_____
Federal rules or standards:	New	_____	Amended	_____	Repealed	_____
Recently enacted state statutes:	New	6	Amended	3	Repealed	1

The number of sections adopted at the request of nongovernmental entity:

	New	_____	Amended	_____	Repealed	_____

The number of sections adopted in the agency's own initiative:

	New	_____	Amended	_____	Repealed	_____

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

	New	_____	Amended	_____	Repealed	_____

The number of sections adopted using:

Negotiated rule making:	New	_____	Amended	_____	Repealed	_____
Pilot rule making:	New	_____	Amended	_____	Repealed	_____
Other alternative rule making:	New	_____	Amended	_____	Repealed	_____

AMENDATORY SECTION (Amending Matter No. R 98-7, filed 9/8/99, effective 10/9/99)

WAC 284-43-130 Definitions. Except as defined in other subchapters and unless the context requires otherwise, the following definitions shall apply throughout this chapter.

(1) "Adverse determination and noncertification" means a decision by a health carrier to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits including the admission to or continued stay in a facility.

(2) "Certification" means a determination by the carrier that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness in relation to the applicable health plan.

(3) "Clinical review criteria" means the written screens, decision rules, medical protocols, or guidelines used by the carrier as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services under the auspices of the applicable health plan.

(4) "Covered health condition" means any disease, illness, injury or condition of health risk covered according to the terms of any health plan.

((~~(2)~~)) (5) "Covered person" means an individual covered by a health plan including an enrollee, subscriber, policyholder, or beneficiary of a group plan.

((~~(3)~~)) (6) "Emergency medical condition" means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

((~~(4)~~)) (7) "Emergency services" means otherwise covered health care services medically necessary to evaluate and treat an emergency medical condition, provided in a hospital emergency department.

((~~(5)~~)) (8) "Enrollee point-of-service cost-sharing" or "cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

((~~(6)~~)) (9) "Facility" means an institution providing health care services, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic settings.

((~~(7)~~)) (10) "Grievance" means a written or an oral complaint submitted by or on behalf of a covered person regarding:

(a) Denial of health care services or payment for health care services; or

(b) Issues other than health care services or payment for health care services including dissatisfaction with health care services, delays in obtaining health care services, conflicts with carrier staff or providers, and dissatisfaction with carrier practices or actions unrelated to health care services.

((~~(8)~~)) (11) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 RCW or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

((~~(9)~~)) (12) "Health care service" or "health service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

((~~(10)~~)) (13) "Health carrier" or "carrier" means a disability insurance company regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, and a health maintenance organization as defined in RCW 48.46.020.

((~~(11)~~)) (14) "Health plan" or "plan" means any individual or group policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care service except the following:

(a) Long-term care insurance governed by chapter 48.84 RCW;

(b) Medicare supplemental health insurance governed by chapter 48.66 RCW;

(c) Limited health care service offered by limited health care service contractors in accordance with RCW 48.44.035;

(d) Disability income;

(e) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;

(f) Workers' compensation coverage;

(g) Accident only coverage;

(h) Specified disease and hospital confinement indemnity when marketed solely as a supplement to a health plan;

(i) Employer-sponsored self-funded health plans;

(j) Dental only and vision only coverage; and

(k) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

((~~(12)~~)) (15) "Managed care plan" means a health plan that coordinates the provision of covered health care services to a covered person through the use of a primary care provider and a network.

((~~(13)~~)) (16) "Medically necessary" or "medical necessity" in regard to mental health services is a carrier determination as to whether a health service is a covered benefit if the service is consistent with generally recognized standards within a relevant health profession.

((~~(14)~~)) (17) "Mental health provider" means a health care provider or a health care facility authorized by state law to provide mental health services.

((~~(15)~~)) (18) "Mental health services" means in-patient or out-patient treatment, partial hospitalization or out-patient treatment to manage or ameliorate the effects of a mental disorder listed in the *Diagnostic and Statistical Manual (DSM) IV* published by the American Psychiatric Association, excluding diagnoses and treatments for substance abuse, 291.0 through 292.9 and 303.0 through 305.9.

((~~(16)~~)) (19) "Network" means the group of participating providers and facilities providing health care services to a particular health plan. A health plan network for carriers offering more than one health plan may be smaller in number than the total number of participating providers and facilities for all plans offered by the carrier.

((~~(17)~~)) (20) "Out-patient therapeutic visit" or "out-patient visit" means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards used by the carrier to determine medical necessity for the particular service being rendered, as defined in *Physicians Current Procedural Terminology,* published by the American Medical Association.

((~~(18)~~)) (21) "Participating provider" and "participating facility" means a facility or provider who, under a contract with the health carrier or with the carrier's contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, from the health carrier rather than from the covered person.

((~~(19)~~)) (22) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

((~~(20)~~)) (23) "Primary care provider" means a participating provider who supervises, coordinates, or provides initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

((~~(21)~~)) (24) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

((~~(22)~~)) (25) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any

assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

((~~(23)~~)) (26) "Small group" means a health plan issued to a small employer as defined under RCW 48.43.005(24) comprising from one to fifty eligible employees.

AMENDATORY SECTION (Amending Matter No. R 99-2, filed 1/24/00, effective 3/1/00)

WAC 284-43-200 Network adequacy. (1) A health carrier shall maintain each plan network in a manner that is sufficient in numbers and types of providers and facilities to assure that all health plan services to covered persons will be accessible without unreasonable delay. Each covered person shall have adequate choice among each type of health care provider, including those types of providers who must be included in the network under WAC 284-43-205. In the case of emergency services, covered persons shall have access twenty-four hours per day, seven days per week. The carrier's service area shall not be created in a manner designed to discriminate against persons because of age, sex, family structure, ethnicity, race, health condition, employment status, or socioeconomic status. Each carrier shall ensure that its networks will meet these requirements by the end of the first year of initial operation((~~; or, for those plans already in existence, by August 22, 1998~~)) of the network and at all times thereafter.

(2) Sufficiency and adequacy of choice may be established by the carrier with reference to any reasonable criteria used by the carrier, including but not limited to: Provider-covered person ratios by specialty, primary care provider-covered person ratios, geographic accessibility, waiting times for appointments with participating providers, hours of operation, and the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care. Evidence of carrier compliance with network adequacy standards that are substantially similar to those standards established by state agency health care purchasers (e.g., the state health care authority and the department of social and health services) and by private managed care accreditation organizations may be used to demonstrate sufficiency. At a minimum, a carrier will be held accountable for meeting those standards described under WAC 284-43-220.

(3) In any case where the health carrier has an absence of or an insufficient number or type of participating providers or facilities to provide a particular covered health care service, the carrier shall ensure through referral by the primary care provider or otherwise that the covered person obtains the covered service from a provider or facility within reasonable proximity of the covered person at no greater cost to the covered person than if the service were obtained from network providers and facilities, or shall make other arrangements acceptable to the commissioner.

(4) The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of network providers and facilities to the business or personal residence of covered persons. Health carriers shall make reasonable efforts to include providers and facilities in networks in a manner that limits the amount of travel required to obtain covered benefits. For example, a carrier should not require travel of thirty miles or more when a provider who meets carrier standards is available for inclusion in the network and practices within five miles of enrollees. In determining whether a health carrier has complied with this provision, the commissioner will give due consideration to the relative availability of health care providers or facilities in the service area under consideration and to the standards established by state agency health care purchasers. Relative availability includes the willingness of providers or facilities in

the service area to contract with the carrier under reasonable terms and conditions.

(5) A health carrier shall monitor, on an ongoing basis, the ability and clinical capacity of its network providers and facilities to furnish health plan services to covered persons.

(6) Beginning July 1, 2000, the health carrier shall disclose to covered persons that limitations or restrictions on access to participating providers and facilities may arise from the health service referral and authorization practices of participating providers and facilities. The carrier shall provide instructions to covered persons as to how they can receive details about such practices from their primary care provider or through other formally established processes. For example, a covered person relying on such instructions or processes could discover if the choice of a particular primary care provider would result in the covered person's inability to obtain a referral to certain other participating providers.

(7) To provide adequate choice to covered persons who are American Indians, each health carrier shall maintain arrangements that ensure that American Indians who are covered persons have access to Indian health care services and facilities that are part of the Indian health system. Carriers shall ensure that such covered persons may obtain covered services from the Indian health system at no greater cost to the covered person than if the service were obtained from network providers and facilities. Carriers are not responsible for credentialing providers and facilities that are part of the Indian health system. Nothing in this subsection prohibits a carrier from limiting coverage to those health services that meet carrier standards for medical necessity, care management, and claims administration or from limiting payment to that amount payable if the health service were obtained from a network provider or facility.

NEW SECTION

WAC 284-43-251 Covered person's access to providers. (1) Each carrier must allow a covered person to choose a primary care provider who is accepting new patients from a list of participating providers. Covered persons also must be permitted to change primary care providers at any time with the change becoming effective no later than the beginning of the month following the covered person's request for the change.

(2) Each carrier must have a process whereby a covered person with a complex or serious medical or psychiatric condition may receive a standing referral to a participating specialist for an extended period of time. The standing referral must be consistent with the covered person's medical needs and plan benefits. For example, a one-month standing referral would not satisfy this requirement when the expected course of treatment was indefinite. However, a referral does not preclude carrier performance of utilization review functions.

(3) Each carrier shall provide covered persons with direct access to the participating chiropractor of the covered person's choice for covered chiropractic health care without the necessity of prior referral. Nothing in this subsection shall prevent carriers from restricting covered persons to seeing only chiropractors who have signed participating provider agreements or from utilizing other managed care and cost containment techniques and processes. For purposes of this subsection, "covered chiropractic health care" means covered benefits and limitations related to chiropractic health

services as stated in the plan's medical coverage agreement, with the exception of any provisions related to prior referral for services.

(4) Each carrier must provide, upon the request of a covered person, access by the covered person to a second opinion regarding any medical diagnosis or treatment plan from a qualified participating provider of the covered person's choice. The carrier may not impose any charge or cost upon the covered person for such second opinion other than a charge or cost imposed for the same service in otherwise similar circumstances.

(5) Each carrier must cover services of a primary care provider whose contract with the plan or whose contract with a subcontractor is being terminated by the plan or subcontractor without cause under the terms of that contract for at least sixty days following notice of termination to the covered persons or, in group coverage arrangements involving periods of open enrollment, only until the end of the next open enrollment period. Notice to covered persons shall include information of the covered person's right of access to the terminating provider for an additional sixty days. The provider's relationship with the carrier or subcontractor must be continued on the same terms and conditions as those of the contract the plan or subcontractor is terminating, except for any provision requiring that the carrier assign new covered persons to the terminated provider.

(6) Each carrier shall make a good faith effort to assure that written notice of a termination within fifteen working days of receipt or issuance of a notice of termination is provided to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause.

SUBCHAPTER D
UTILIZATION REVIEW

NEW SECTION

WAC 284-43-410 Utilization review--Generally. (1) Each carrier shall maintain a documented utilization review program description and written clinical review criteria based on reasonable medical evidence. The program must include a method for reviewing and updating criteria. Carriers shall make clinical review criteria available upon request to participating providers. A carrier need not use medical evidence or standards in its utilization review of religious nonmedical treatment or religious nonmedical nursing care.

(2) The utilization review program shall meet accepted national certification standards such as those used by the National Committee for Quality Assurance except as otherwise required by this chapter and shall have staff who are properly qualified, trained, supervised, and supported by explicit written clinical review criteria and review procedures.

(3) Each carrier when conducting utilization review shall:

(a) Accept information from any reasonably reliable source that will assist in the certification process;

(b) Collect only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services;

(c) Not routinely require providers or facilities to numerically code diagnoses or procedures to be considered for certification, but may request such codes, if available;

(d) Not routinely request copies of medical records on all patients reviewed;

(e) Require only the section(s) of the medical record during prospective review or concurrent review necessary in that specific case to certify medical necessity or appropriateness of the admission or extension of stay, frequency or duration of service;

(f) For prospective and concurrent review, base review determinations solely on the medical information obtained by the carrier at the time of the review determination;

(g) For retrospective review, base review determinations solely on the medical information available to the attending physician or order provider at the time the health service was provided;

(h) Not retrospectively deny coverage for emergency and nonemergency care that had prior authorization under the plan's written policies at the time the care was rendered unless the prior authorization was based upon a material misrepresentation by the provider;

(i) Not retrospectively deny coverage or payment for care based upon standards or protocols not communicated to the provider or facility within a sufficient time period for the provider or facility to modify care in accordance with such standard or protocol; and

(j) Reverse its certification determination only when information provided to the carrier is materially different from that which was reasonably available at the time of the original determination.

(4) Each carrier shall reimburse reasonable costs of medical record duplication for reviews.

(5) Each carrier shall have written procedures to assure that reviews and second opinions are conducted in a timely manner.

(a) Review determinations must be made within two business days of receipt of the necessary information on a proposed admission or service requiring a review determination.

(b) The frequency of reviews for the extension of initial determinations must be based upon the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity.

(c) Retrospective review determinations must be completed within thirty days of receipt of the necessary information.

(d) Notification of the determination shall be provided to the attending physician or ordering provider or facility and to the covered person within two days of the determination and shall be provided within one day of concurrent review determination. Notification shall include the number of extended days, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services.

(6) No carrier may penalize or threaten a provider or facility with a reduction in future payment or termination of participating provider or participating facility status because the provider or facility disputes the carrier's determination with respect to coverage or payment for health care service.

SUBCHAPTER F
GRIEVANCE AND COMPLAINT PROCEDURES

NEW SECTION

WAC 284-43-615 Grievance and complaint procedures--Generally. (1) Each carrier must adopt and implement a comprehensive process for the resolution of covered persons' grievances and appeals of adverse determinations. This process shall meet accepted national certification standards such as those used by the National Committee for Quality Assurance except as otherwise required by this chapter.

(2) This process must conform to the provisions of this chapter and each carrier must:

(a) Provide a clear explanation of the grievance process upon request, upon enrollment to new covered persons, and annually to covered person and subcontractors of the carrier.

(b) Ensure that the grievance process is accessible to enrollees who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to file a grievance.

(c) Process as a grievance a covered person's expression of dissatisfaction about customer service or the quality or availability of a health service.

(d) Implement procedures for registering and responding to oral and written grievances in a timely and thorough manner including the notification of a covered person that a grievance or appeal has been received.

(e) Assist the covered person with all grievance and appeal processes.

(f) Cooperate with any representative authorized in writing by the covered person.

(g) Consider all information submitted by the covered person or representative.

(h) Investigate and resolve all grievances and appeals.

(i) Provide information on the covered person's right to obtain second opinions.

(j) Track each appeal until final resolution; maintain, and make accessible to the commissioner for a period of three years, a log of all appeals; and identify and evaluate trends in appeals.

AMENDATORY SECTION (Amending Matter No. R 98-17, filed 11/29/99, effective 12/30/99)

WAC 284-43-620 Procedures for ((~~health care service review decisions~~)) review and appeal of adverse determinations. (1) A covered person or the covered person's representative, including the treating provider (regardless of whether the provider is affiliated with the carrier) acting on behalf of the covered person may appeal an adverse determination in writing. The carrier must reconsider the adverse determination and notify the covered person of its decision within fourteen days of receipt of the appeal unless the carrier notifies the covered person that an extension is necessary to complete the appeal; however, the extension cannot delay the decision beyond thirty days of the request for appeal, without the informed, written consent of the coverage person.

(2) Whenever a health carrier makes an adverse determination and delay would jeopardize the covered person's life or materially jeopardize the covered person's health, the carrier shall expedite and process either a written or an oral appeal and issue a decision no later than seventy-two hours after receipt of the appeal. If the treating health care provider determines that delay ((~~would~~)) could jeopardize the covered ((~~person's life or materially jeopardize the~~)) person's health or ability to regain maximum function, the carrier shall presume the need for expeditious review, including the need for an expeditious determination in any independent review under WAC 284-43-630.

(3) A carrier may not take or threaten to take any punitive action against a provider acting on behalf or in support of a covered person appealing an adverse determination.

(4) Appeals of adverse determinations shall be evaluated by health care providers who were not involved in the initial decision and who have appropriate expertise in the field of medicine that encompasses the covered person's condition or disease.

(5) All appeals must include a review of all relevant information submitted by the covered person or a provider acting on behalf of the covered person.

(6) The carrier shall issue to affected parties and to any provider acting on behalf of the covered person a written notification of the adverse determination that includes the actual reasons for the determination, the instructions for obtaining an appeal of the carrier's decision, a written statement of the clinical rationale for the decision, and instructions for obtaining the clinical review criteria used to make the determination.

NEW SECTION

WAC 284-43-630 Independent review of adverse determinations. (1) A covered person may seek review by a certified independent review organization of an adverse decision after exhausting the carrier's grievance process and receiving a decision that is unfavorable to the covered person, or after the carrier has exceeded the timelines for grievances provided in this chapter, without good cause and without reaching a decision. Upon prior written approval of the carrier's process by the commissioner, a carrier may establish a process to bypass the carrier's internal grievance process and allow for the direct appeal to a certified independent review organization for certain classes of adverse determinations.

(2) Carriers must provide to the appropriate independent review organization certified by the department of health and designated by the commissioner's rotational registry, not later than the third business day after the date the carrier receives a request for review, a copy of:

(a) Any medical records of the covered person that are relevant to the review;

(b) Any documents used by the carrier in making the determination to be reviewed by the certified independent review organization; including relevant clinical review criteria used by the carrier and other relevant medical, scientific, and cost-effectiveness evidence;

(c) Any documentation and written information submitted to the carrier in support of the appeal;

(d) A list of each physician or health care provider who has provided care to the covered person and who may have medical records relevant to the appeal. Health information or other confidential or proprietary information

in the custody of a carrier may be provided to an independent review organization, subject to the privacy provisions of Title 284 WAC;

(e) The attending or ordering provider's recommendations; and

(f) The terms and conditions of coverage under the relevant health plan.

The carrier shall also make available to the covered person and to any provider acting on behalf of the covered person all materials provided to an independent review organization reviewing the carrier's determination. The carrier may also require the covered person and any provider acting on behalf of a covered person to make available to the carrier information provided to an independent review organization in support of an appeal.

(3) The medical reviewers from a certified independent review organization shall make determinations regarding the medical necessity or appropriateness of, and the application of health plan coverage provisions to, health care services for a covered person. The medical reviewers' determinations must be based upon their expert medical judgment, after consideration of relevant medical, scientific, and cost-effectiveness evidence, and medical standards of practice in the state of Washington. Except as provided in this subsection, the certified independent review organization must ensure that determinations are consistent with the scope of covered benefits as outlined in the medical coverage agreement. Medical reviewers may override the health plan's medical necessity or appropriateness standards if the standards are determined upon review to be unreasonable or inconsistent with sound, evidence-based medical practice.

(4) Once a request for an independent review determination has been made, the independent review organization must proceed to a final determination, unless requested otherwise by both the carrier and the covered person or covered person's representative.

(5) Carriers must implement the certified independent review organization's determination promptly, and must pay the certified independent review organization's charges.

NEW SECTION

WAC 284-43-820 Health plan disclosures--Prescription drugs, preventive care, generally. (1) A carrier that offers a health plan may not offer to sell a health plan to an enrollee or to any group representative, agent, employer, or enrollee representative without first offering to provide, and providing upon request, the following information using a standardized summary format filed with the commissioner and consistent with WAC 284-43-815 before purchase or selection:

(a) A listing of covered benefits, including prescription drug benefits, if any, and how consumers may be involved in decisions about benefits;

(b) A listing of exclusions, reductions, and limitations to covered benefits, including definitions of terms such as formulary, generic versus brand name, medical necessity or other coverage criteria and policies regarding coverage of drugs, including how drugs are added or removed from the formulary;

(c) A statement of the carrier's policies for protecting the confidentiality of health information;

(d) A statement of the cost of premiums and any enrollee cost-sharing requirements;

(e) A summary explanation of the carrier's grievance process;

(f) A statement regarding the availability of a point-of-service option, if any, and how the option operates; and

(g) A convenient means of obtaining a complete and detailed list of covered benefits including a copy of the current formulary, if any is used, a list of participating primary care and specialty care providers, including disclosure of network arrangements that restrict access to providers within any plan network. The offer to provide the information referenced in this subsection (1) must be clearly and prominently displayed on any information provided to any prospective enrollee or to any prospective group representative, agent, employer, or enrollee representative.

(2) Upon the request of any person, including a current enrollee, prospective enrollee, or the insurance commissioner, a carrier must provide written information regarding any health care plan it offers, that includes the following written information:

(a) Any documents, instruments, or other information referred to in the medical coverage agreement;

(b) A full description of the procedures to be followed by an enrollee for consulting a provider other than the primary care provider and whether the enrollee's primary care provider, the carrier's medical director, or another entity must authorize the referral;

(c) Procedures, if any, that an enrollee must first follow for obtaining prior authorization for health care services;

(d) A written description of any reimbursement or payment arrangements, including, but not limited to, capitation provisions, fee-for-service provisions, and health care delivery efficiency provisions, between a carrier and a provider or network;

(e) Descriptions and justifications for provider compensation programs, including any incentives or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to specialists;

(f) An annual accounting of all payments made by the carrier which have been counted against any payment limitations, visit limitations, or other overall limitations on a person's coverage under a plan;

(g) A copy of the carrier's grievance process for claim or service denial and for dissatisfaction with care; and

(h) Accreditation status with one or more national managed care accreditation organizations, and whether the carrier tracks its health care effectiveness performance using the health employer data information set (HEDIS), whether it publicly reports its HEDIS data, and how interested persons can access its HEDIS data.

(3) Each carrier shall provide to all enrollees and prospective enrollees a list of available disclosure items.

(4) Nothing in this section requires a carrier or a health care provider to divulge proprietary information to an enrollee, including the specific contractual terms and conditions between a carrier and a particular provider.

(5) No carrier may advertise or market any health plan to the public, including to any employer as a plan that covers services that help prevent illness or promote the health of enrollees unless it:

(a) Provides all clinical preventive health services provided by the basic health plan, authorized by chapter 70.47 RCW;

(b) Monitors and reports annually to enrollees on standardized measures of health care and satisfaction of all enrollees in the health plan. Standardized measures for this purpose, include HEDIS, consumer assessment of health plans (CAHP) or other national standardized measurement systems adopted by national managed care accreditation organizations or state agencies that purchase managed health care services and approved by the commissioner; and

(c) Makes available upon request to enrollees its integrated plan to identify and manage the most prevalent diseases within its enrolled

population, including cancer, heart disease, and stroke. Such plans must include means to identify enrollees with these diseases, implement evidence based screening, education, monitoring and treatment protocols, track patient and provider adherence to these protocols, measure health outcomes, and regularly report results to enrollees.

(6) No carrier may preclude or discourage its providers from informing an enrollee of the care he or she requires, including various treatment options, and whether in the providers' view such care is consistent with the plan's health coverage criteria, or otherwise covered by the enrollee's medical coverage agreement with the carrier. No carrier may prohibit, discourage, or penalize a provider otherwise practicing in compliance with the law from advocating on behalf of an enrollee with a carrier. Nothing in this section shall be construed to authorize a provider to bind a carrier to pay for any service.

(7) No carrier may preclude or discourage enrollees or those paying for their coverage from discussing the comparative merits of different carriers with their providers. This prohibition specifically includes prohibiting or limiting providers participating in those discussions even if critical of a carrier.

(8) Each carrier must communicate enrollee information required in this act by means that ensure that a substantial portion of the enrollee population can make use of the information.

NEW SECTION

WAC 284-43-899 Effective date. The effective date of WAC 284-43-130, 284-43-200, 284-43-251, 284-43-400, 284-43-410, 284-43-610, 284-43-615, 284-43-620, 284-43-630, and 284-43-820 is July 1, 2001.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 284-43-610 Definitions.